day was: red cells, 5,840,000 per c.mm.; Hb, 14 g.; P.C.V., 52%; M.C.V., 89 μ^3 ; M.C.H.C., 27%; white cells, 10,000 per c.mm. The water-excretion test (Kepler-Power) was carried out on the 24th post-operative day and gave the following results: largest volume of day urine, 21 ml.; volume of night urine, 72 ml.; urine urea, 3.4 g.; urine chlorides, 320 mg./100 ml.; plasma sodium chloride, 565 mg./100 ml.; plasma urea, 45 mg./100 ml.; value of "A," 33. The urine contained 285 mg. of uroporphyrin per litre at the time of death.

Post-mortem Examination.—The lungs showed mucopus in the larger bronchi and patches of unresolved pneumonia at both bases. No abnormality was detected macroscopically in any of the other systems. Sections of the lungs showed bronchopneumonia. Sections of the brain and spinal cord showed none of the characteristic features of the disease.

Family History.—The mother died, aged 49 years, of a "stroke," the father in his seventies with "dropsy." Three brothers and two sisters are well; their urines were examined, and none contained porphyrins. Two cousins on the mother's side died young—one at 23 years, diagnosed as from acute ascending myelitis, the other at 21 years, diagnosed as from anxiety neurosis and pneumonia.

Discussion

Porphyria is a disease believed to be due to an inborn error of metabolism which results in the circulation of an excess of porphyrins in the blood. It has been suggested that porphyrins exert a toxic action, particularly on nervous tissue (Mason, Courville, and Ziskind, 1933; Vannotti, 1937; Thorner, 1937). The condition was first described as a clinical entity by Günther (1911). Since then a number of cases have been reported, particularly in Scandinavian and American literature, and the condition has been excellently reviewed by Nesbitt (1944). In this country attention has been drawn to the disease only recently (Chandler, Harrison, and Rimington, 1939; Discombe and D'Silva, 1945; Jörgensen and With, 1947; Abrahams, Gavey, and MacLagan, 1947; Discombe, 1948; Petrie, 1948; Davies, 1949; Gibson, Harrison, and Montgomery, 1950; Hart and Collard, 1950).

This case presents a number of the usual features of the disease. The patient had abdominal pain, neurological manifestations, tachycardia, and arterial hypertension, and she passed pigmented urine. But the most interesting and confusing feature was the marked guarding and tenderness in the right hypochondrium; this is a feature which has not been reported before, and was very largely responsible for the delay in arriving at the correct diagnosis. Her family history is also interesting, as the stories of the fatal illnesses of her two cousins suggest that they, too, may have suffered from acute porphyria.

The serum chloride and sodium levels were estimated and the Kepler-Power test was carried out because it has been suggested that there is some adrenal insufficiency in this disease (Abrahams, Gavey, and MacLagan, 1947). This contention cannot be supported by the present case. The lowering of the serum chloride and serum sodium has also been attributed to impaired renal function rather than adrenal disturbances (Davies, 1949), but again in this case we could find no evidence of renal disorder. Since this patient's serum sodium and chloride values showed no significant deviation from normal we cannot expect to throw light on this particular problem, but it is evident from this case that lowering of sodium and chloride concentration in the serum is not an invariable accompaniment of the disease.

Various drugs such as sulphonal, methylsulphonal, barbiturates, lead, etc., have been incriminated in the production of this disease. This patient stated that she did not take any drugs before her admission.

My thanks are due to Mr. W. A. Mackey for his advice and encouragement, to Dr. J. W. Chambers and Dr. A. Dick for carrying out the biochemical and pathological investigations, and to Professor Rimington for doing the estimation of porphyrin.

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Medical Memoranda

Failure of Aureomycin in Dermatitis Herpetiformis

Conflicting reports of the value of "aureomycin" have been published recently. In America Robinson *et al.* (1949) treated five cases of dermatitis herpetiformis with from 1 to 2 g. of the antibiotic daily. They reported invariable relief from itching and involution of vesicles within one to two weeks, and that the response was more rapid and satisfactory than could be expected with any previously known treatment. Clarence Shaw (1950) used aureomycin in two patients suffering from dermatitis herpetiformis and reported complete failure to influence the course of the disease in either patient. The dosage he used was 1 g. daily for two weeks.

Recently I have had the opportunity of treating a severe case of dermatitis herpetiformis with this drug.

Case Report

A married woman aged 68 developed erythema of both forearms in May, 1950. By July the lesions had become vesicular, involving the forearms and backs of hands, and spreading rapidly to the legs, thighs, buttocks, face, and neck, with groups of vesicles and bullae scattered over the chest and back, and accompanied by considerable itching. At no time were the mucous membranes affected.

Before admission she had received a course of penicillin injections (2,500,000 units in a week), then a course of sulphadimidine (32 g. in four days), and, finally, sulphapyridine 1 g. four times daily for a week (total, 28 g.). No improvement was noted with these measures, vesicles and bullae continued to form, and she was admitted to hospital.

Investigations.—Bulla fluid contained "a few leucocytes—no eosinophils." The patch test (potassium iodide, 20% in soft paraffin) was strongly positive. Nikolsky's sign could not be elicited. Blood eosinophilia varied between 13% and 34%. Biopsy report: "A subepidermal bulla, in the floor and lumen of which are numerous eosinophils. There is no evidence of pemphigus. Diagnosis—dermatitis herpetiformis."

Aureomycin capsules were administered orally in dosage of 250 mg. four times daily for seven days, and then increased to 500 mg. for a further two weeks. In all, a total of 35 g. was given in three weeks. At no time was there any objective or subjective improvement in the condition. The bullae continued to form (some as large as a walnut) and became increasingly widespread. No toxic side-effects were noted apart from a feeling of warmth and excessive sweating.

Aureomycin was considered to have been valueless in this case, and was discontinued. The patient was then given liquor arsenicalis, 10 min. (0.6 ml.) four times daily, and within a week her general condition had improved, the erythema lessened, and no further vesicles formed. She was discharged from hospital two weeks later with the disease apparently controlled by the arsenic.

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Cholelithiasis in a Boy of 10 Presenting as Acute Appendicitis

The following case is of interest because of the comparative rarity of such a condition in children, and because it presented as an apparently classical case of acute appendicitis.

Case Report

The patient, a boy aged 10, was admitted to hospital on September 5, 1949, at 8.45 a.m. At 11 p.m. the previous night he had complained of the sudden onset of periumbilical pain; this had persisted overnight, getting worse at times and then better. Early on the morning of admission it had shifted to the right iliac fossa, where it remained, of fairly severe intensity and sharp in character. Shortly after the onset of abdominal pain he had vomited up his tea and supper, and this had made the pain worse. His bowels had not moved since the onset of pain. There was no dysuria or frequency. He had had a similar but less severe attack four days before admission, lasting only an hour or so. There was nothing relevant in his previous history. His mother said that he had always been a very healthy youngster.

On examination his general condition was fairly good. His skin was a good colour, and there was neither pallor nor flushing of his cheeks. His temperature was 98.4° F. (36.9° C.) and his pulse 96. The abdomen was not moving very freely on respiration, and there was guarding over and also tenderness in the right iliac fossa. Rövsing's sign was positive. Nothing abnormal was found in the cardiovascular, respiratory, and central nervous systems.

A diagnosis of acute appendicitis was made, and the child was taken to the theatre for laparotomy at 2 p.m. on the day of admission.

Operation.—The abdomen was opened through a right lower paramedian incision, and the appendix was found in the ileo-caecal angle; it was about 4 in. (10 cm.) in length and the seat of a mucocoele, but not of any actual infection. In view of the negative findings in the appendix, the mesentery was examined carefully for any sign of acute non-specific mesenteric adenitis. However, only a few glands were found, some partially and some completely calcified, presumably from an old tuberculous infection.

Palpation higher up on the right side of the abdomen revealed a greatly distended transverse colon and a sausage-shaped mass below the edge of the liver. The original incision was lengthened at this point to give easier access to the liver and gall-bladder region. The gall-bladder was found to be grossly distended and inflamed; it was two to

three times its normal size, and a stone was palpated in Hartmann's pouch. In view of the great distension of the transverse colon and the relative smallness of the patient, it was decided not to attempt to remove the gall-bladder. The stone was milked back into the fundus of the gall-bladder, a purse-string suture inserted, and a small incision made over the stone, which was then delivered. The purse-string suture was tightened and tied. A corrugated-rubber drain was inserted under the right costal margin and brought out through a stab incision in the right flank. The abdomen was closed in layers.

Pathological Report on the Gall-stone.—Macroscopic examination revealed a tar-coloured waxy stone $\frac{1}{2}$ in. (1.25 cm.) in diameter, containing a nucleus of brown material of somewhat softer consistence. It was a mixed stone, composed mainly of cholesterol, with traces of bile pigment, calcium, phosphates, and fatty material.

Post-operative progress was good. The patient was given a course of sulphadiazine over five days, and this settled a slight pyrexia. The drain was removed on the ninth post-operative day. He was discharged on September 22 feeling very well indeed.

Comment

While the comparative rarity of cholelithiasis and cholecystitis in children in itself gives interest to this case, the complete absence of symptoms and signs referable to gall-bladder disease is of even more interest.

Ladd and Gross in *The Abdominal Surgery of Childhood* state that only about 450 cases of gall-bladder disease in children are recorded in the literature. They find that cholelithiasis is commoner than acute cholecystitis, and say that the stones tend to remain in the gall-bladder. The commonest symptoms are right upper quadrant pain, nausea, vomiting, and fever. The commonest cause of gall-stone formation in children is said to be haemolytic anaemia. This case showed no evidence of such an aetiology.

I should like to thank Mr. Douglas G. Martin, surgeon-superintendent, St. Richard's Hospital, Chichester, for permission to publish this case.

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The Principal of the University of London (*Report for the Year 1950-1*) refers to the impact of the National Health Service Act on the facilities for medical education, which continues to create problems. Following on last year's dispute with the Ministry of Health over the function and remuneration of registrars in the London teaching hospitals, which was finally settled to the satisfaction of the University, the Ministry issued in November its well-known circular suggesting drastic reductions in the numbers of registrars. However, the problems involved are receiving further consideration, and the Ministry appears to be ready to compromise, though nothing has as yet been settled. The Ministry has now amended the Appointment of Specialists Regulations in a way which for the most part meets the objections raised by the universities. Concerning clinical posts, where the salaries are paid out of university funds, each university is now free to make its own arrangements with the teaching hospital concerned. In addition universities have been allowed four representatives out of eight on the appointment boards which make recommendations about filling posts on the staffs of teaching hospitals. For the first time since 1933 the undergraduate medical schools of the University of London were visited on behalf of the Senate by inspectors; they drew attention to a number of serious deficiencies, the most important being the shortage of clinical facilities in the teaching hospitals. A report of their findings and the recommendations made has been sent to the Ministry.